FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039636

Facility Name: CAHOKIA NURSING & REHAB CTR

Address: 2 ANNABELLE COURT (Number) CAHOKIA (City) 62206 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 332-0114 **Fax #** (618) 332-1043

IDPA ID Number: 363952442001

Date of Initial License for Current Owners: 06/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,472	484	4,309	12,265	8
9	SNF/PED					9
10	ICF	24,703	761		25,464	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,175	1,245	4,309	37,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.91%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started June 1, 1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date June 1, 1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 3,614

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	187,234	23,179		210,413		210,413	(1,198)	209,215			1
2	Food Purchase		145,281		145,281		145,281	(48)	145,233			2
3	Housekeeping	142,387	85,180		227,567		227,567		227,567			3
4	Laundry	72,665	28,617		101,282		101,282		101,282			4
5	Heat and Other Utilities			112,839	112,839		112,839	1,740	114,579			5
6	Maintenance	29,203	26,956	8,617	64,776		64,776	(598)	64,178			6
7	Other (specify):*											7
8	**TOTAL General Services**	431,489	309,213	121,456	862,158		862,158	(104)	862,054			8
	B. Health Care and Programs											
9	Medical Director			4,400	4,400		4,400		4,400			9
10	Nursing and Medical Records	1,346,270	21,334	7,788	1,375,392		1,375,392	(16,978)	1,358,414			10
10a	Therapy	69,861		5,753	75,614		75,614		75,614			10a
11	Activities	50,165	3,321		53,486		53,486		53,486			11
12	Social Services	47,074			47,074		47,074		47,074			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,513,370	24,655	17,941	1,555,966		1,555,966	(16,978)	1,538,988			16
	C. General Administration											
17	Administrative	153,636		120,000	273,636		273,636	(35,444)	238,192			17
18	Directors Fees											18
19	Professional Services			125,829	125,829		125,829	(101,888)	23,941			19
20	Dues, Fees, Subscriptions & Promotions			16,555	16,555		16,555	(5,891)	10,664			20
21	Clerical & General Office Expenses	227,754	3,607	41,571	272,932		272,932	46,369	319,301			21
22	Employee Benefits & Payroll Taxes			343,875	343,875		343,875		343,875			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,141	2,141		2,141	7	2,148			24
25	Other Admin. Staff Transportation			4,615	4,615		4,615	416	5,031			25
26	Insurance-Prop.Liab.Malpractice			115,140	115,140		115,140	1,143	116,283			26
27	Other (specify):*							8,725	8,725			27
28	**TOTAL General Administration**	381,390	3,607	769,726	1,154,723		1,154,723	(86,564)	1,068,159			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,326,249	337,475	909,123	3,572,847		3,572,847	(103,646)	3,469,201			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR #0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,020	22,020		22,020	191,498	213,518			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,114	16,114		16,114	218,437	234,551			32
33	Real Estate Taxes			(3,139)	(3,139)		(3,139)	131,194	128,055			33
34	Rent-Facility & Grounds			600,000	600,000		600,000	(600,000)				34
35	Rent-Equipment & Vehicles			14,168	14,168		14,168	1,132	15,300			35
36	Other (specify):*							39,937	39,937			36
37	**TOTAL Ownership**			649,163	649,163		649,163	(17,802)	631,361			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,734	234,901	313,635		313,635		313,635			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		78,734	317,026	395,760		395,760		395,760			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,326,249	416,209	1,875,312	4,617,770		4,617,770	(121,448)	4,496,322			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,170	30		9
10	Interest and Other Investment Income	(4,707)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,773)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,091)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(168,416)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (174,866)		$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	53,418		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 53,418		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (121,448)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OHF USE ONLY								
48		49		50		51		52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
CAHOKIA NURSING & REHAB CTR

ID# 0039636
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	ILLINOIS COUNCIL LTC - COPE	$ (182)	20	1
2	LEGAL - NON-ALLOWABLE	(381)	19	2
3				3
4	VETERANS - PHARMACY	(15,183)	10	4
5	THEFT & DAMAGE LOSS	(250)	21	5
6	ROBIN SUYDAN - ADMIN. SALARY	29,516	17	6
7	ROBIN SUYDAN - PR TAXES	2,259	27	7
8	R.O. AMORTIZ. OF MORTG. COSTS	(3,812)	31	8
9	R.O. LEGAL FEES	(554)	19	9
10	CAPITALIZED R&M	(2,254)	6	10
11				11
12	R.O. APPRAISAL COSTS - NON-ALLOW.	(8,800)	33	12
13	R.O. INTEREST EXPENSE (BONDS)	(88,627)	32	13
14	BETSY GASTON - ADMIN.SALARY	(35,194)	17	14
15	BETSY GASTON - PR TAXES	(2,692)	27	15
16	JEFF DAVIS - ADMIN.SALARY	(39,258)	17	16
17	JEFF DAVIS - PR. TAXES	(3,004)	27	17
18				18
19				19
20				20
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23				23
24				24
25				25
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99				99
100				100
101	Total	(168,416)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(1,198)								(1,198)	1
2	Food Purchase	(48)											(48)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,740									1,740	5
6	Maintenance	(2,254)		1,656									(598)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,302)		3,396	(1,198)								(104)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,183)			(1,795)								(16,978)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(15,183)			(1,795)								(16,978)	16
	C. General Administration													
17	Administrative	(44,936)		9,492									(35,444)	17
18	Directors Fees													18
19	Professional Services	(935)	554	(101,507)									(101,888)	19
20	Fees, Subscriptions & Promotions	(5,955)		64									(5,891)	20
21	Clerical & General Office Expenses	(2,341)		48,710									46,369	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			7									7	24
25	Other Admin. Staff Transportation			416									416	25
26	Insurance-Prop.Liab.Malpractice			1,143									1,143	26
27	Other (specify):*	(3,437)		12,162									8,725	27
28	**TOTAL General Administration**	(57,605)	554	(29,513)									(86,564)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(75,090)	554	(26,117)	(2,993)								(103,646)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,170	183,425	1,903									191,498	30
31	Amortization of Pre-Op. & Org.	(3,812)	3,812											31
32	Interest	(93,334)	310,305	1,466									218,437	32
33	Real Estate Taxes	(8,800)	136,160	3,834									131,194	33
34	Rent-Facility & Grounds		(600,000)										(600,000)	34
35	Rent-Equipment & Vehicles			1,132									1,132	35
36	Other (specify):*		39,937										39,937	36
37	**TOTAL Ownership**	(99,776)	73,639	8,335									(17,802)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(174,866)	74,193	(17,782)	(2,993)								(121,448)	45

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 600,000	CAHOKIA PROPERLY LLC		$	$ (600,000)	1
2	V	32	INTEREST INCOME	28,767	CAHOKIA PROPERLY LLC			(28,767)	2
3	V	33	APPRAISAL COSTS		CAHOKIA PROPERLY LLC		8,800	8,800	3
4	V	32	MORTGAGE INTEREST		CAHOKIA PROPERLY LLC		250,445	250,445	4
5	V	32	INTEREST EXPENSE		CAHOKIA PROPERLY LLC		88,627	88,627	5
6	V	33	R.E. TAXES		CAHOKIA PROPERLY LLC		127,360	127,360	6
7	V	36	M.I.P. INSURANCE		CAHOKIA PROPERLY LLC		39,937	39,937	7
8	V	31	AMORTIZATION MORTG.		CAHOKIA PROPERLY LLC		3,812	3,812	8
9	V	30	DEPRECIATION EXPENSE		CAHOKIA PROPERLY LLC		183,425	183,425	9
10	V	19	LEGAL FEES		CAHOKIA PROPERLY LLC		554	554	10
11	V								11
12	V								12
13	V								13
14	Total			$ 628,767			$ 702,960	$ * 74,193	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.W. MANAGEMENT	100.00%	$ 1,740	$ 1,740	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT		1,656	1,656	16
17	V	17	CHIEF FINANCIAL OFFICER		S.W. MANAGEMENT		16,264	16,264	17
18	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT		493	493	18
19	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT		64	64	19
20	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT		48,710	48,710	20
21	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT		7	7	21
22	V	25	TRANSPORTATION		S.W. MANAGEMENT		416	416	22
23	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT		1,143	1,143	23
24	V	27	PAYROLL TAXES		S.W. MANAGEMENT		9,565	9,565	24
25	V	30	DEPRECIATION		S.W. MANAGEMENT		1,903	1,903	25
26	V	32	INTEREST EXPENSE		S.W. MANAGEMENT		1,466	1,466	26
27	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT		3,834	3,834	27
28	V	35	AUTO LEASE		S.W. MANAGEMENT		1,132	1,132	28
29	V								29
30	V	17	SALARY - SHELDON WOLFE		S,W, MANAGEMENT		48,228	48,228	30
31	V	17	SALARY - RONNIE KLEIN		S,W, MANAGEMENT		5,000	5,000	31
32	V	27	EMP. BEN.-SHELDON WOLFE		S,W, MANAGEMENT		1,901	1,901	32
33	V	27	EMP. BEN.-RONNIE KLEIN		S,W, MANAGEMENT		696	696	33
34	V								34
35	V	17	MANAGEMENT FEES	60,000				(60,000)	35
36	V	19	HOME OFFICE FEES	102,000				(102,000)	36
37	V								37
38	V								38
39	Total			$ 162,000			$ 144,218	$ * (17,782)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SUPPLEMENTS	$ 11,984	S & E MEDICAL SUPPLY	100.00%	$ 10,786	$ (1,198)	15
16	V	10	MEDICAL SUPPLIES	8,974	S & E MEDICAL SUPPLY	100.00%	7,179	(1,795)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 20,958			$ 17,965	$ * (2,993)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON WOLFE	OWNER	Administrative	23.67%	See Attached	4.5	7.50%	SW MGMT	$ 48,228	17-7	1
2	RONNIE KLEIN	OWNER	Administrative	5.00%	See Attached	5	8.33%	SW MGMT	5,000	17-7	2
3	RONNIE KLEIN	OWNER	Administrative	5.00%	See Attached	5	8.33%	Fees-Facility	60,000	17-3	3
4	MO HERMAN	CFO	Financial	0.67%	See Attached	4.5	11.25%	Sal-SW Mgmt	16,264	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 129,492		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. MANAGEMENT
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	Available Bed Days	488,314	8	$ 15,521	$	54,750	$ 1,740	1
2	6	REPAIRS AND MAINT.	Available Bed Days	488,314	8	14,771		54,750	1,656	2
3	17	CHIEF FINANCIAL OFFICER	Available Bed Days	488,314	8	145,056	145,056	54,750	16,264	3
4	19	PROFESSIONAL FEES	Available Bed Days	488,314	8	4,393		54,750	493	4
5	20	FEES, SUBSCRIPTIONS, DUES	Available Bed Days	488,314	8	572		54,750	64	5
6	21	CLERICAL AND GENERAL	Available Bed Days	488,314	8	434,445	380,978	54,750	48,710	6
7	24	EDUCATION AND SEMINARS	Available Bed Days	488,314	8	59		54,750	7	7
8	25	TRANSPORTATION	Available Bed Days	488,314	8	3,708		54,750	416	8
9	26	INSURANCE - PROPERTY	Available Bed Days	488,314	8	10,197		54,750	1,143	9
10	27	PAYROLL TAXES	Available Bed Days	488,314	8	85,313		54,750	9,565	10
11	30	DEPRECIATION	Available Bed Days	488,314	8	16,972		54,750	1,903	11
12	32	INTEREST EXPENSE	Available Bed Days	488,314	8	13,072		54,750	1,466	12
13	33	REAL ESTATE TAXES	Available Bed Days	488,314	8	34,195		54,750	3,834	13
14	35	AUTO LEASE	Available Bed Days	488,314	8	10,092		54,750	1,132	14
15										15
16	17	SALARY - SHELDON WOLFE	Avg. Hours Worked	60	9	643,036	643,036	5	48,228	16
17	17	SALARY - RONNIE KLEIN	Avg. Hours Worked	60	7	60,000	60,000	5	5,000	17
18	27	EMP. BEN.-SHELDON WOLFE	Avg. Hours Worked	60	9	25,346		5	1,901	18
19	27	EMP. BEN.-RONNIE KLEIN	Avg. Hours Worked	60	7	8,354		5	696	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,525,102	$ 1,229,070		$ 144,218	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E MEDICAL SUPPLY
Street Address: 3100 COMMERCIAL AVENUE
City / State / Zip Code: NORTHBROOK, ILLINOIS 60062
Phone Number: (847) 982-9300
Fax Number: (847)982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SUPPLEMENTS	Direct Allocation						10,786	1
2	10	MEDICAL SUPPLIES	Direct Allocation						7,179	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 17,965	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MORTGAGE	X					$	$ 3,929,327			$ 250,445	1
2												2
3												3
4												4
5												5
	Working Capital											
6	NP STOCKHOLDERS	X						574,333			16,114	6
7												7
8												8
9	TOTAL Facility Related						$	$ 4,503,660			$ 266,559	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(32,008)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (32,008)	14
15	TOTALS (line 9+line14)						$	$ 4,503,660			$ 234,551	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 39,937 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME	X					$	$			$ (4,707)	1
2	INTEREST INCOME - BLDG	X									(28,767)	2
3	ALLOC. SW MGMT	X									1,466	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (32,008)	21

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	121,783	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	123,836	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,053	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	126,002	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	128,055	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	109,482	8
	1998	99,340	9
	1999	118,306	10
	2000	115,983	11
	2001	120,002	12

R.E. Taxes Accrual 2002 - Estimated at 122,126 x 1.05 = 126,002

Alloc. S.W. MGMT - $3,834 - Included above on ln 2

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CAHOKIA NURSING & REHAB CTR COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0039636

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.	06-02.0-310-055	Long Term Care Property	$ 120,001.72	$ 120,001.72
4.	10-28-412-049-000	S.W. Mgmt Alloc	$ 35,720.85	$ 3,843.86
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 155,722.57	$ 123,845.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CAHOKIA NURSING & REHAB CTR COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0039636

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories ONE

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		2001	$ 230,000	1
2					2
3	TOTALS			$ 230,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	17,857		20	1,264	1,264	10,528	9
10	Various			1995	33,623		20	1,681	1,681	13,006	10
11	Various			1996	2,178		20	109	109	727	11
12	Various			1997	9,423		20	471	471	2,593	12
13	Various			1998	4,800		20	240	240	1,080	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,987,646	84,080		84,505	425	103,654	68
69	Financial Statement Depreciation			7,254			(7,254)		69
70	TOTAL (lines 4 thru 69)		$ 3,055,527	$ 91,334		$ 88,270	$ (3,064)	$ 131,588	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,055,527	$ 91,334		$ 88,270	$ (3,064)	$ 131,588	1
2	DAMPERS	1999	3,646		20	182	182	728	2
3	WATER HEATER	1999	6,689		20	334	334	1,308	3
4	HEATER BOOSTER	1999	1,105		20	55	55	202	4
5	INSTALL HEATER BOOST	1999	250		20	13	13	48	5
6	WATER HEATER	1999	4,575		20	229	229	744	6
7	AIR HANDLER	2000	1,516		20	291	291	1,079	7
8	ALARM SYSTEM	2001	1,908		20	611	611	993	8
9	BLIND	2001	1,212		20	388	388	631	9
10	AIR HANDLER	2001	1,317		20	66	66	99	10
11	FAN MOTOR	2001	1,123		20	56	56	61	11
12	DRYWALL-DINING ROOM	2002	10,650		20	888	888	888	12
13	DOOR	2002	9,860		20	41	41	41	13
14	AIR CONDITIONER	2002	1,199		20	100	100	100	14
15	AIR CONDITIONER	2002	1,582		20	132	132	132	15
16	AIR CONDITIONERS	2002	4,284		20	306	306	306	16
17	COMPRESSOR AIR MAXI	2002	1,269		20	121	121	121	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,107,712	$ 91,334		$ 92,083	$ 749	$ 139,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1995		$ 48,427	$ 1,242	35	$ 1,384	$ 142	$ 10,591	4
5											5
6	150		2001		2,747,665	70,453	39	70,453		76,324	6
7											7
8											8
	Improvement Type**										
9											9
10	CAHOKIA PROPERTY LLC			2001	180,786	12,052	20	12,052		13,057	10
11											11
12	SW MGMT			1995	5,177	173	20	309	(136)	2,297	12
13	SW MGMT			1996	904	23	20	45	22	297	13
14	SW MGMT			1997	1,302	50	20	93	43	491	14
15	SW MGMT			1998	896	23	20	45	22	213	15
16	SW MGMT			1999	2,489	64	20	124	60	384	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,987,646	$ 84,080		$ 84,505	$ 153	$ 103,654	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 789,644	$ 101,064	$ 120,818	$ 19,754	10	$ 219,817	71
72	Current Year Purchases	7,157	14,950	617	(14,333)	10	617	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 796,801	$ 116,014	$ 121,435	$ 5,421		$ 220,434	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,134,513	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 207,348	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 213,518	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,170	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 359,503	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	BMW	$ 841.00	$ 10,092	17
18	ADMINISTRATIVE	BMW	#######	4,076	18
19	ADMINISTRATIVE	ALLOC SW MGMT		1,132	19
20					20
21	TOTAL		$ #######	$ 15,300	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 126,961	$		$ 126,961	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			25,733			25,733	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			82,207			82,207	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				73,725		73,725	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						5,009		5,009	13
14	TOTAL			$		$ 234,901	$ 78,734		$ 313,635	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 438,996	$ 534,415	1
2	Cash-Patient Deposits	17,869	17,869	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	983,195	983,195	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,588	39,144	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(211,126)	(211,126)	8
9	Other(specify): See Supplemental Schedule	11,250	373,853	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,259,772	$ 1,737,350	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		230,000	13
14	Buildings, at Historical Cost		2,747,665	14
15	Leasehold Improvements, at Historical Cost	54,757	235,543	15
16	Equipment, at Historical Cost	231,591	845,197	16
17	Accumulated Depreciation (book methods)	(224,960)	(423,669)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		133,435	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 61,388	$ 3,768,171	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,321,160	$ 5,505,521	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 130,456	$ 273,880	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,183	21,183	28
29	Short-Term Notes Payable	574,333	574,333	29
30	Accrued Salaries Payable	93,755	93,755	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,880	12,880	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,002	32
33	Accrued Interest Payable		20,793	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule		4,123	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 832,607	$ 1,126,949	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,929,327	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,929,327	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 832,607	$ 5,056,276	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 488,553	$ 449,245	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,321,160	$ 5,505,521	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 687,899	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 687,899	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(199,346)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (199,346)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 488,553	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,200,228	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,200,228	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	157,096	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 157,096	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,103	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 27,103	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,707	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,707	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	29,290	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 29,290	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,418,424	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	862,158	31
32	Health Care	1,555,966	32
33	General Administration	1,154,723	33
	B. Capital Expense		
34	Ownership	649,163	34
	C. Ancillary Expense		
35	Special Cost Centers	313,635	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,617,770	40
41	**Income before Income Taxes (line 30 minus line 40)****	(199,346)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (199,346)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,028	$ 52,209	$ 25.74	1
2	Assistant Director of Nursing	1,952	1,984	45,446	22.91	2
3	Registered Nurses	6,571	6,811	142,207	20.88	3
4	Licensed Practical Nurses	20,975	22,085	389,462	17.63	4
5	Nurse Aides & Orderlies	37,313	80,694	716,946	8.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,586	6,249	69,861	11.18	8
9	Activity Director					9
10	Activity Assistants	5,408	5,697	50,165	8.81	10
11	Social Service Workers	3,733	4,019	47,074	11.71	11
12	Dietician					12
13	Food Service Supervisor	1,955	2,075	25,256	12.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,322	20,087	161,978	8.06	15
16	Dishwashers					16
17	Maintenance Workers	2,522	2,628	29,203	11.11	17
18	Housekeepers	18,187	19,068	142,387	7.47	18
19	Laundry	11,071	11,274	72,665	6.45	19
20	Administrator	1,632	1,728	41,956	24.28	20
21	Assistant Administrator					21
22	Other Administrative	3,890	4,160	111,680	26.85	22
23	Office Manager					23
24	Clerical	16,164	16,800	227,754	13.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	158,249	207,387	$ 2,326,249 *	$ 11.22	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	80	4,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	119	7,360	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	128	5,753	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	327	$ 17,513		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		428	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 428		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SANDRA PRESSON	ADMINISTRATOR	0	$ 41,956
JEFF DAVIS	Administrative	0	58,888
BETSY GASTON	Administrative	0	52,792
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 153,636

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 60,000
RONNIE KLEIN	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE	LEGAL	$ 3,230
SW MANAGEMENT	HOME OFFICE FEES	102,000
FR&R	ACCOUNTING	18,970
PERSONNEL PLANNERS INC.	UNEMPLOYMENT CLST	1,629
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 125,829

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,539
Unemployment Compensation Insurance	37,534
FICA Taxes	177,951
Employee Health Insurance	67,117
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,452
Misc.Employee Benefits/Disability	11,527
Holiday Expense	755
TOTAL (agree to Schedule V, line 22, col.8)	$ 343,875

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,039
Health Care Worker Background Check	1,310
(Indicate # of checks performed 13)	
ILL Council LTC	5,893
Dues & Subscriptions	295
Licenses	1,063
Alloc. SW Mgmt	64
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,664

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,141
Alloc. S.W. Mgmt	7
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,148

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CAHOKIA NURSING & REHAB CTR # 0039636 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Ill Council -LTC - $6,075**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees